Pay for Performance: National Perspective

2006 Longitudinal Survey Results with 2007 Market Updates

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The Leapfrog Group
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Bridges to Excellence	Endorser
National Business Coalition on Health	Endorser
National Committee on Quality Assurance (NCQA)	Endorser
National Quality Forum	Endorser
Pacific Business Group on Health (PBGH)	Endorser
Rewarding Results National Evaluation Team	Endorser
Center for Health Care Strategies, Inc.	Endorser

Agenda

- National Context
- Physician Practices
- Hospitals
- Lessons Learned
- Next Generation

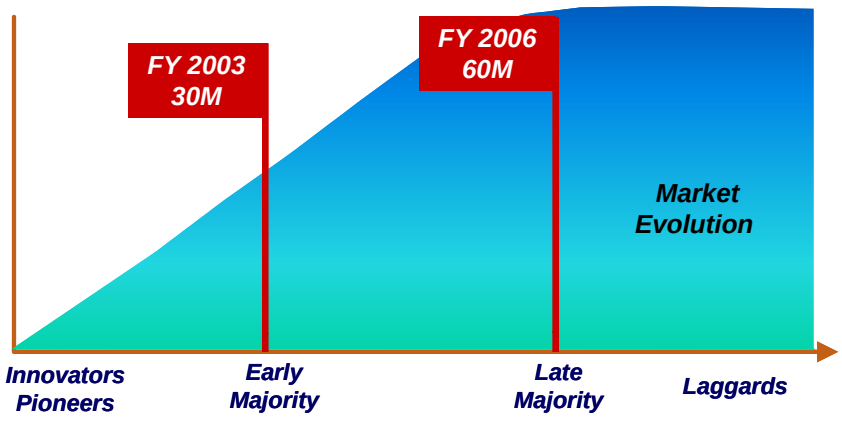
National Context

Survey Overview

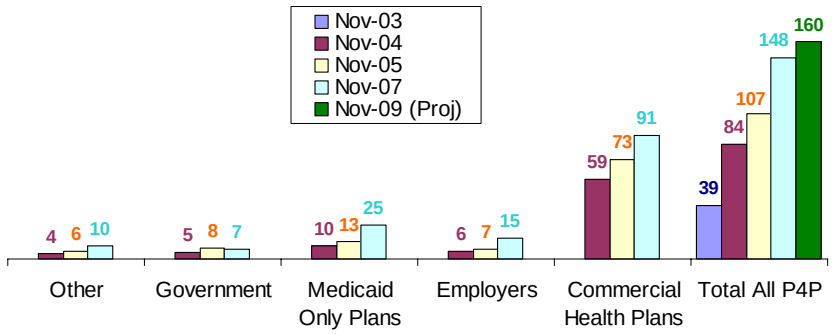
This survey evaluates the trends and implications for provider Pay-for-Performance ("P4P") incentive programs in health care. This is the third annual survey with selected longitudinal results since 2003.

- 75 web-based survey respondents representing 185M subscribers with 35M subscribers in P4P programs.
- Conducted in Q1, 2007 for 2006 results
- Empirical research in December 2007 to supplement findings

P4P Market Adoption has Matured



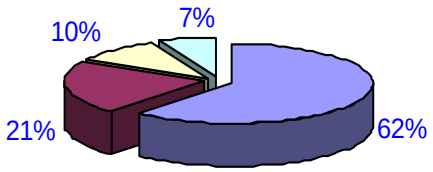
Growth in P4P Programs by Sponsor Type



Note: For "Other" in 2007, we included disease management programs and vendors with P4P incentives under the primary program sponsor (Medicaid) and 10 projected implementations

CMS and States Will Assume the P4P $Tab

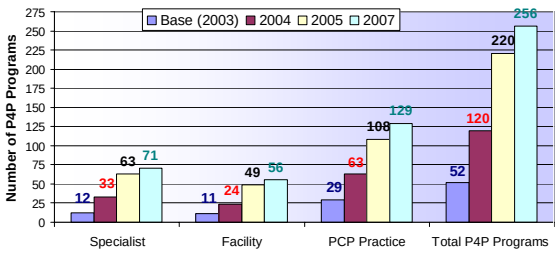
2007 P4P Programs by Sponsor Type
% of Total (n=148)



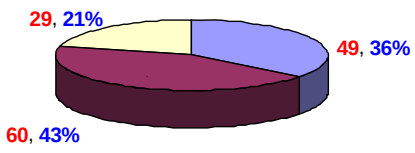
Commercial Payer Programs
Government (State/CMS)
Coalition/Employer
Projected for '07 Deployment

P4P Incentives Extend to All Providers

P4P Program by Provider Type: 2003-2007 Trend



# of Programs by P4P Sponsor
2007 (n=138), % of Total



1P4P Program
2 P4P Programs
3 Programs (PCP, Specialist, Facility)

The P4P Evolution Roadmap

	Stage 1 1996-2003	Stage 2 2004-2006	Stage 3 2007-2010
Features	• PCP HEDIS measures • Hospital measures • Minimal consumer reporting • HMO product line • Withhold or Bonus based payouts	• PCP + Facility measures, Multiple specialties • Balanced Scorecard • EB quality and affordability measures • All product lines • Differential fee schedules	• Enhanced data collection, clinical data exchanges, data aggregation • Standardized measures + outcomes • Efficiency • Actionable info - registries, reminder alerts • PHR – EHR integration • Transparency
Benefits	• Informational • Low impact on cost • Preventive care • Existing data sets	• Static consumer report cards • Safety and medication errors • Provider IT investment • Collection of non-claims data (lab values, etc.)	• Enhanced Provider Directories (Provider ratings) • Demonstrable ROI • Financially Sustainable • Member engagement (PHR) • Point of care notification

There are Multiple Incentive Models Used by Purchaser, Health Plan and Government Payers in the US Healthcare System

Which of the following TYPES of P4P or incentive programs does your organization operate?	Response Total	Response Percent
Physicians—payment of financial incentives to individual physicians, small physician practices or organized physician groups (IPAs and medical groups)	68	91%
Hospitals—payment of financial incentives to hospitals	26	35%
Health Plans—payment of financial incentives to health plans	2	3%
Consumer health plan choice—premium or benefit differential for choosing high-value health plans	1	1%
Consumer hospital choice—benefit (e.g. co-pay or coinsurance) differential for choosing high-value hospitals	3	4%
Consumer physician choice—benefit (e.g. co-pay or coinsurance) differential for choosing high-value physicians	8	11%
Consumer pharmaceutical choice—benefit (e.g. co-pay or coinsurance) differential for choosing high-value pharmaceuticals	11	15%
Consumer healthy behavior choice—incentives for participating in health promotion or health management activities	16	21%
Total Respondents		75

Reasons for Implementing P4P Programs

Criteria for Implementing P4P	Mean 2006 (n=62)	Mean 2005 (n=60)	Mean 2004 (n=50)
Improve patients' clinical outcomes	4.63	4.36	4.60
Improve member experience (e.g., patient satisfaction)	4.00	N/A	N/A
Differentiate in the market, convey positive image	4.00	3.62	3.64
Drive standardization of performance measures	3.93	N/A	N/A
Align with other initiatives (e.g., disease management, high performance networks, consumer-directed benefit designs, consumer-directed provider report cards)	3.75	3.57	4.02
Reduce medical errors/improve patient safety	3.63	3.3	3.68
Improve bottom line, lower cost	3.53	3.24	3.28
Improve data collection and reporting from providers	3.53	2.99	3.44
Respond to employer pressures	3.14	2.74	2.87

Using a scale from 1-5, where 1 equals NOT important and 5 equals VERY important

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Physician Practices

Physician P4P Domains (2005-2006)

What performance DOMAINS are you measuring in your P4P program and what are their relative WEIGHTS?	2006 Average % (n=52)	2005 Average % (n=76)
Clinical quality (process or outcome measures)	58.43	51.56
Patient safety or medical error reduction	10.38	15
Efficiency or cost of care	22.74	34.74
Patient satisfaction or experience of care	13.15	22.12
Clinical health information technology adoption (EHR, e-prescribing, registries, e-lab, etc.)	14.74	21.45
Administrative capability, such as electronic claims submission	8.27	15.36
Member access, such as open panel or evening hours	4.67	N/A
Other	16.15	44.95

Types of Payments to Physicians (2004-2006)

What type of incentive PAYMENTS do you make to Providers?	2006 Percent (n=55)	2005 Percent (n=72)	2004 Percent (n=50)
Bonus	73%	79%	86%
Payments from a withhold pool	11%	15%	26%
Differential fee schedule, paid prospectively	15%	22%	16%
Increased capitation payment, paid prospectively	5%	7%	0%
Additional reimbursement for specific tasks	18%	22%	30%
Quality grants	5%	6%	18%
Other	9%	N/A	6%

*Totals may exceed 100% because multiple answers were tabulated.

Impact of P4P Programs on Physician Practices

Results from P4P Program	2006 Percent (n=33)
Performance on clinical measures has improved	**76%**
Performance on patient surveys has improved	**21%**
Cost performance has improved: either a positive Return on Investment (ROI), a net cost savings, or the trend in cost increases has slowed	**30%**
Members have shifted to high performing physicians	**3%**
Physicians have invested in QI or electronic systems	**30%**
None of the above have taken place	**6%**
Too early to tell the effects	**18%**
Other	**9%**

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Hospitals

Hospital P4P Domains (2005-2006)

What performance DOMAINS are you measuring in your P4P program and what are their relative WEIGHTS?	2006 Average % Weight (n=14)	2005 Average % Weight (n=27)
Clinical quality (process or outcome measures)	64.5	47.9
Patient safety or medical error reduction	34.7	34.1
Efficiency or cost of care	10	29.6
Utilization	15	N/A
Patient satisfaction or experience of care	11.67	11.75
Clinical health IT adoption (EHRs, registries, e-prescribing, e-lab, etc)	12.5	12.5
Community service	0	5
Administrative	50	9.6
Other	0	75.5

Types of Payments to Hospitals (2005-2006)

What type of incentive PAYMENTS do you make to hospitals?	2006 Percent (n=14)	2005 Percent (n=30)
Bonus	64%	60%
Payments from a withhold pool	14%	20%
Enhanced DRG payment schedule prospectively	21%	30%
Additional reimbursement for specific tasks	7%	20%
Payment for previously unreimbursed services	0%	N/A
Quality grants	7%	3%
Other	7%	N/A

Impact of P4P Programs on Hospitals

What results, if any, do you attribute to your pay-for-performance program?	2006 Percent (n=9)
Performance on clinical measures has improved	67%
Performance on patient surveys has improved	22%
Cost performance has improved: either a positive Return on Investment (ROI), a net cost savings, or the trend in cost increases has slowed	11%
Consumers have shifted to high performing hospitals	0%
Hospitals have invested in QI or electronic systems	11%
None of the above have taken place	0%
Too early to tell the effects	33%
Anecdotal improvements to hospital administration interest in quality	11%

Level of Improvement Resulting from P4P Program Intervention

HOW MUCH improvement have you experienced?	2006 Percent (n=26)
Clinical performance improved but not significantly	31%
Clinical performance improved significantly	65%
Patient survey results improved but not significantly	12%
Patient survey results improved significantly	12%
There has been a net cost savings	15%
The trend in cost increases has slowed	19%
The program has demonstrated a positive return on investment (ROI)	15%

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Lessons Learned

Recommendations for New P4P Programs

Based on what you have learned so far about P4P programs, what are the TWO most important RECOMMENDATIONS you would make to other organizations that are seeking to implement or to refine their existing P4P program?	2006 Percent (n=52)	2005 Percent (n=82)
Involve providers early in the design	58%	74%
Use well-established or co-authored measures	63%	63%
Be willing to make changes over time	29%	49%
Be clear about your ROI expectations	6%	10%
Pilot the P4P measures or reporting formats before full implementation	25%	32%
Use public reporting as a reputational incentive	6%	18%
Other	10%	9%

Anticipated Changes in P4P Program

Changes anticipated in next 2 years to P4P Program	2006 Percent (n=46)	2005 Percent (n=82)
Expand program to include other products (e.g. PPO, ASO, CDH)	20%	40%
Expand program to include specialists if not doing so now	33%	40%
Expand program to include additional specialties	26%	35%
Expand program to include hospitals if not doing so now	24%	27%
Expand the scope or number of measures used	70%	N/A
Change the performance domains or relative weighting	39%	67%
Develop a public performance report	33%	43%
Tie the P4P program more closely to disease management, tiered networks, or benefit design initiatives	33%	N/A
Discontinue the program	0%	N/A
Other	27%	21%

Data Aggregation –
Participation in state-wide, collaborative quality initiatives

Road Ahead: Key Trends for P4P

- Going beyond process measures (admin data)
- Physicians acting upon “actionable information” (buy-in first)
- Better support and reporting tools
- Data aggregation, clinical exchange, clinical values
- Multiple outreach mediums
- Increased communication frequency
- Clinical measure impact is demonstrable
- Second attempt at efficiency (Are we reducing trends yet?)
- CMS is now in business
- Push for standardization
- Rush towards transparency (beware)